Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

## Medical Assistance Administration


# Enteral Nutrition

## Billing Instructions

## Chapter 388-554 WAC

# About this publication

**This publication supersedes any other versions of MAA's *Medical Nutrition Billing Instructions* and Numbered Memoranda 00-64 MAA, 03-49 MAA, 03-68 MAA, 04-14 MAA, and 04-54 MAA.**

Related programs have their own billing instructions. Services and/or equipment related to any of the programs listed below must be billed using their respective billing instructions:

- Home Health Services
- Hospice Agency Services
- Medical Nutrition Therapy
- Prescription Drug Program

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# Where do I get copies of other billing instructions?

To obtain MAA's provider numbered memoranda and billing instructions, go to MAA's website at http://maa.dshs.wa.gov (click on the Billing Instructions/Numbered Memoranda or Provider Publications/Fee Schedules link).

To request a free hard copy from the Department of Printing:

- **Go to: http://www.prt.wa.gov/** (Orders filled daily**)**
  Click on General Store. Follow prompts to Store Lobby → Search by Agency → Department of Social and Health Services → Medical Assistance Administration → desired issuance; **or**

- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX (360) 586-6361/ telephone (360) 586-6360. (Orders may take up to 2 weeks to fill.)

# Table of Contents

# Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. **[WAC 388-502-0020(2)].**

**How do I obtain information to become a DSHS provider, to submit a change of address or ownership, or to ask questions about the status of a provider application?**

**Contact Provider Enrollment:**
http://maa.dshs.wa.gov/provrel/ or
(866) 545-0544 (toll free)

**Where do I send my claims?**

**Electronic Claims:**
Providers who would like to access the *free* WAMedWeb application can enroll now by contacting ACS EDI Gateway via telephone at (800) 833-2051 (toll free) or visit https://wamedweb.acs-inc.com/wa/general/home.do

**Hard Copy Claims:**
Division of Program Support
PO Box 9247
Olympia WA 98507-9247

**How can I obtain copies of billing instructions or numbered memoranda?**

To **view and download**, visit: http://maa.dshs.wa.gov and click on *Billing Instructions/Numbered Memoranda*.

To **have a hard copy sent** to you, visit: http://www.prt.wa.gov/ and click on *General Store.*

**How do I obtain prior authorization?**

**Fax a completed Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-743] request to:**

Division of Medical Management
Program Management and Authorization Section
Attn: Enteral Nutrition Program Manager

(360) 725-1967 Fax

**How do I obtain a limitation extension?**

Complete the *Justification for use of B9998 Miscellaneous Enteral Nutrition Procedure Code and Limitation Extension Request Form* [DSHS 13-745] and fax it to:

(360) 725-1967 Fax

**How do I find the nearest Women, Infants, and Children (WIC) clinic?**

To find the nearest WIC clinic, call:

(800) 322-2588

**Where do I call if I have questions regarding…**

**Private insurance or third-party liability, other than Healthy Options?**

Coordination of Benefits Section
(800) 562-6136

**How do I obtain DSHS forms?**

To **download** DSHS forms, visit: http://www1.dshs.wa.gov/msa/forms/eforms.html

To **have a paper copy sent** to you:

**Phone** DSHS Forms and Records Management Service: (360) 664-6047

**Fax** DSHS Forms and Records Management Service: (360) 664-6186

Be sure to include in your request:

- The form number and name;
- The quantity you want;
- Your name;
- Your office/organization name; and
- Your complete mailing address.

# Definitions

**This section defines terms and acronyms used throughout these billing instructions.**

**Acute** - A medical condition of severe intensity with sudden onset.

**Authorization** – MAA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

**Body Mass Index** - A number that shows body weight adjusted by height, and is calculated using inches and pounds or meters and kilograms. [WAC 388-554-200]

**By Report (BR) -** When a service, supply, or piece of equipment is new (its use is not yet considered standard), or it is a variation on a standard practice, or it is rarely provided, or it has no maximum allowance established, it may be designated ***By Report***. Any service or item classified as ***By Report*** is evaluated for its medical appropriateness and maximum allowance on a case-by-case basis.

**Client –** An applicant for, or recipient of, DSHS medical care programs.

**Code of Federal Regulations (CFR)** – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

**Community Services Office (CSO)** - An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

**Department** - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

**Durable Medical Equipment (DME)** – Equipment that:

(a) Can withstand repeated use;
(b) Is primarily and customarily used to serve a medical purpose;
(c) Generally is not useful to a person in the absence of illness or injury; and
(d) Is appropriate for use in the client's place of residence. [WAC 388-543-1000]

**Duration of Therapy** - The estimated span of time that therapy will be needed for a medical problem.

**Emergency Services** - Services provided for care required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

**Enteral Nutrition –** The use of medically necessary nutrition products alone, or in combination with traditional food, when a client is unable to consume enough traditional food to meet nutrition requirements. Enteral nutrition solutions can be given orally or via feeding tubes. [WAC 388-554-200]

**Enteral Nutrition Equipment** - Durable medical feeding pumps and intravenous (IV) poles used in conjunction with nutrition supplies to dispense formula to a client. [WAC 388-554-200]

**Enteral Nutrition Product** - Enteral nutrition formulas and/or products. [WAC 388-554-200]

**Enteral Nutrition Supplies** - The supplies, such as nasogastric, gastrostomy and jejunostomy tubes, necessary to allow nutritional support via the alimentary canal or any route connected to the gastrointestinal system.

**Explanation of Benefits (EOB)** - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

**Explanation of Medicare Benefits (EOMB) –** A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

**Growth chart** - A series of percentile curves that illustrate the distribution of select body measurements (i.e. height, weight, and age) in children published by the Centers for Disease Control (CDC) and Prevention, National Center for Health Statistics. CDC growth charts: United States. http://www.cdc.gov/growthcharts/.

**Internal Control Number (ICN)** - A 17-digit number that appears on your *Remittance and Status Report* by the client's name. Each claim is assigned an ICN when it is received by MAA. The number identifies that claim throughout the claim's history.

**Limitation Extension** – Prior authorization from MAA to exceed the service limits (quantity, frequency, or duration) set in Washington Administrative Code (WAC) or in MAA's billing instructions.

**Managed Care** - A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. These services are provided either through a managed care organization (MCO) or primary care case management (PCCM) provider. [WAC 388-538-050]

**Maximum Allowable** - The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

**Medicaid** - The state and federal funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

**Medical Assistance Administration (MAA)** - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

**Medical Care Provider** – Physician, physician assistant (PA), advanced registered nurse practitioner (ARNP), and certified dietitian.

**Medical Consultant** - A physician employed by the department. [WAC 388-500-0005]

**Medically Necessary** – A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

**Medical Nutrition Therapy** – Face-to-face interactions between a certified dietician and a client or the client's guardian for the purpose of evaluating the client's nutrition and making recommendations regarding the client's nutrition status or treatment.

**Medicare** - The Federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

**Nonfunctioning Digestive Tract** – Is caused by a condition that affects the body's alimentary organs and their ability to breakdown and digest nutrients.

**Orally Administered Enteral Nutrition Products** - Enteral nutrition products that a client consumes orally for nutrition support.

**Patient Identification Code (PIC)** - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

**Prior Authorization –** Written MAA approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. *Expedited prior authorization and limitation extensions are forms of prior authorization.*

**Provider or Provider of Service** - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

**Provider Number** – A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with MAA.

**Purchase Only (P.O.)** - A type of purchase used only when either the cost of the item makes purchasing it more cost effective than renting it, or it is a personal item, such as a ventilator mask, appropriate only for a single user.

**Remittance And Status Report (RA) -** A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

**Rental** - A monthly or daily rental fee paid for equipment.

**Revised Code of Washington (RCW)** - Washington State laws.

**Skilled Nursing Facility (SNF)** - An institution or part of an institution which is primarily engaged in providing:

- Skilled nursing care and related services for residents who require medical or nursing care;
- Rehabilitation services for injured, disabled or sick clients;
- Health-related care and services to individuals who, because of their mental or physical conditions, require care which can only be provided through institutional facilities and which is not primarily for the care and treatment of mental diseases. (See Section 1919(a) of the Federal Social Security Act for specific requirements.)

**Third Party** - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

**Title XIX** - The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

**Total Enteral Nutrition** – Enteral nutrition used to meet 100% of a client's nutrition requirement.

**Tube Delivery** - The provision of nutrition requirements through a tube into the stomach or small intestine.

**Usual & Customary Fee -** The fee that the provider typically charges the general public for the product or service. MAA does not pay shipping and handling.

**Washington Administrative Code (WAC)** Codified rules of the State of Washington.

**WIC (Women, Infants and Children) program -** A special supplemental nutrition program that serves to safeguard the health of low-income women, infants, and children up to age five who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referral to health care. WIC is administered at the Federal level by the Food and Nutrition Service (FNS).

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# About the Program

## What is the purpose of MAA's Enteral Nutrition program?
**[Refer to WAC 388-554-100]**

The Medical Assistance Administration's (MAA's) Enteral Nutrition program covers the products, equipment, and supplies to provide medically necessary enteral nutrition to eligible medical assistance clients. MAA reimburses for enteral nutrition to meet the nutritional and caloric needs required to sustain the health of an eligible medical assistance client when defined as medically necessary by MAA.

**Note:** MAA does not cover enteral nutrition services for clients who, for cognitive or emotional/psychiatric reasons, will not take in enough traditional nutrition to maintain weight; and/or refusal of traditional oral nutrition is not adequate justification for enteral nutrition. **[Refer to WAC 388-554-300 (4)(b)(viii)]**

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# Provider Requirements

## Who is eligible to bill for enteral nutrition?

**[Refer to WAC 388-554-400]**

A provider of oral enteral nutrition products and tube-delivered enteral nutrition products, necessary equipment, and supplies must:

- Have a current core provider agreement with the Medical Assistance Administration (MAA); and
- Be one of the following provider types:
  - ✓ Pharmacy provider; or
  - ✓ Durable medical equipment (DME) provider.

To be eligible for payment for *oral* enteral nutrition products and *tube-delivered* enteral nutrition products, necessary equipment, and supplies, an eligible provider must:

- Meet the requirements in WAC 388-502-0020 [General requirements for providers] and other applicable WAC;
- Obtain prior authorization (PA), if required, before delivery to the client and before billing MAA. See Prior Authorization section for PA requirements;
- Deliver orally administered enteral nutrition products in quantities sufficient to meet a client's medically authorized needs, not to exceed a one-month supply;
- Bill MAA for the authorized products and submit a claim for payment to MAA with a date of service being the same as the shipping date;
- Confirm with the client and document in the client's file that the next month's delivery of authorized orally administered enteral nutrition products is necessary [see WAC 388-554-300(4)]. MAA does not pay for automatic periodic delivery of products;
- Notify and inform the client's physician if the client has indicated the product is not being used as prescribed;

MAA may recoup any payment made to a provider for authorized enteral nutrition products if the requirements in this section are not met.

See *Important Contacts* section for information on applying for a provider number.

# Notifying Clients of Their Rights (Advance Directives)

**(42 CFR, Subpart I)**

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give ***all adult clients*** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

# Client Eligibility

## Who is eligible for Enteral Nutrition Services?

**[Refer to WAC 388-554-300 (1)]**

Clients presenting Medical Identification (ID) cards with the following identifiers ***are eligible*** to receive oral enteral nutrition products and tube-delivered enteral nutrition products and necessary equipment and supplies:

| Medical ID Identifier | Medical Program |
|---|---|
| **CNP** | Categorically Needy Program |
| **CNP - CHIP** | Categorically Needy Program –<br>Children's Health Insurance Program |
| **GA-U No Out of State Care** | General Assistance – Unemployable |
| **General Assistance**<br>**No Out of State Care** | ADATSA |
| **LCP - MNP** | Limited Casualty Program-Medically Needy Program |
| **QMB-Medicare Only** | Qualified Medicare Beneficiary –<br>Medicare Only<br>**See page L.3 for details of coverage.** |

☞ **Note:** All clients age 20 and younger must be evaluated by a certified dietician with a current MAA provider number within 30 days of initiation of enteral nutrition products, and periodically (at the discretion of the certified dietician) while receiving enteral nutrition products. See Provider Requirements for further details.
**[Refer to WAC 388-554-300 (2)]**

# Are clients enrolled in MAA managed care eligible for enteral nutrition? [Refer to WAC 388-554-300 (3)]

**Yes!** Clients whose Medical ID cards have an HMO identifier in the HMO column are enrolled in one of MAA's managed care plans. Clients enrolled in an MAA managed care plan are eligible for oral enteral nutrition products and tube-delivered enteral nutrition products and necessary equipment and supplies through that plan. If a client becomes enrolled in a managed care plan before MAA completes the purchase (or rental, if applicable) of prescribed enteral nutrition products, necessary equipment, and supplies:

- MAA rescinds the purchase until the managed care primary care provider (PCP) evaluates the client; and
- The managed care plan's applicable reimbursement policies apply to the purchase of the products, necessary equipment, and supplies, or rental of the equipment, as applicable.

The plan's name and toll-free telephone number is located on the client's Medical ID card.

> ☞ **Note:** To prevent billing denials, please check the client's Medical ID card ***prior*** to scheduling services and at the ***time of the service*** to make sure proper authorization or referral is obtained from the plan.

# Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM provider, the identifier in the HMO column will be "PCCM." These clients must obtain services through, or be referred by, the PCCM provider. The PCCM provider is responsible for coordination of care just like a PCP would be in a plan setting. Please refer to the client's Medical ID card for the PCCM identifying information. (See the *Billing* section for further information.)

> ☞ **Note:** To prevent billing denials, please check the client's Medical ID card ***prior*** to scheduling services and at the ***time of the service*** to make sure proper authorization or referral is obtained from the PCCM provider.

# What further requirements must clients meet to be eligible for orally administered enteral nutrition products?

**[Refer to WAC 388-554-300(4)]**

To receive **orally** administered enteral nutrition products, a client must:

1) Have a completed Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-743] or Expedited Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-761] from a physician, advanced registered nurse practitioner (ARNP), or physician's assistant-certified (PA-C) for all enteral nutrition products;

2) Be able to manage their feedings in one of the following ways:

   a) Independently; or
   b) With a caregiver who can manage the feedings; and

3) Have at least one of the following medical conditions, subject to the criteria listed:

   a) Acquired Immune Deficiency Syndrome (AIDS).

      Requires PA for a maximum of 1 year per request. MAA considers ICD-9-CM diagnosis code 042 as medically necessary. The client must:

      i. Be in a wasting state;

      ii. Have a weight for length at or less than the fifth percentile if the client is younger than age 3;

      iii. Have a body mass index (BMI) of:

      A. Less than the fifth percentile if the client is older than age 3 and younger than age 18; or

      B. Less than or equal to 18.5 if the client is 18 years of age or older; or

      - An unintentional or unexplained weight loss of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months.

b) Amino acid, fatty acid, and carbohydrate metabolic disorders. (Use EPA # 870001103)

Requires EPA for a maximum of 1 year. MAA considers the following ICD-9-CM codes as medically necessary: 270 through 270.8, 271 through 271.8, and 272.0 through 272.8. The client must require a specialized nutrition product.

c) Cancer(s). (Use EPA # 870001101.)

Requires EPA for a maximum of 1 year. MAA considers the following ICD-9-CM codes as medically necessary: 140 through 208.9 and 230 through 234.9. The client must be currently receiving chemotherapy and/or radiation therapy. Providers may also use this code to bill for the post therapy phase (up to 3 months following the completion of chemotherapy or radiation therapy).

d) Chronic renal failure. (Use EPA # 870001100.)

Requires EPA for a maximum of 1 year. MAA considers ICD-9-CM diagnosis code 585.6 as medically necessary. The client must be receiving dialysis.

**Note:** Clients receiving dialysis must have a fluid restrictive diet in order to use nutrition bars (see page F.7 for more information). When billing for nutrition bars, use EPA # 870000868 for a maximum of 1 year.

e) Decubitus pressure ulcer(s). (Use EPA # 870001102.)

Requires EPA for a maximum of 3 months. MAA considers ICD-9-CM diagnosis code 707.0 – 707.09 as medically necessary. The client must have:

i. Stage 3 or greater decubitus pressure ulcer(s); and
ii. An albumin level of 3.2 or below.

f) End Stage COPD or Emphysema. (Use EPA # 870001105)

Requires EPA for a maximum of 1 year. MAA considers ICD-9-CM diagnosis codes 491.20, 491.21, 492.8, or 496 as medically necessary. The client must have:

i. A BMI of 18.5 or less; or
ii. An unintentional or unexplained weight loss of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months.

g) Failure to thrive.

Requires PA for a maximum of 1 year per request. MAA considers ICD-9-CM diagnosis code 783.41 as medically necessary. The client must have:

i. A disease or medical condition that is only organic in nature and not due to cognitive, emotional, or psychological impairment; and

ii. A weight-for-length at or less than the fifth percentile if the client is younger than age 3; or

iii. A BMI of:

A. Less than or equal to the fifth percentile if the client is at least age 3 but younger than age 18; or

B. Less than or equal to 18.5, an albumin level of 3.5 or below, and a cholesterol level of 160 or below if the client is 18 years of age or older; or

iv. An unintentional or unexplained weight loss of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months.

h) Malnutrition/malabsorption as a result of a stated primary diagnosed disease.

Requires prior authorization (PA) for a maximum of 1 year per request. MAA considers the following ICD-9-CM codes to be medically necessary: 260, 261, 263.0, 263.2, 579.0, 579.2, and 579.8. The client must have:

i. A weight-for-length at or less than the fifth percentile if the client is younger than age 3;

ii. A BMI of:

A. Less than or equal to the fifth percentile if the client is older than age 3 and younger than age 18; or

B. Less than or equal to 18.5 if the client is 18 years of age or older; or

iii. An unintentional or unexplained weight loss of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months.

i) Medical Conditions Requiring a Thickener. **(Use EPA # 870001104)**

Requires EPA for a maximum of 1 year. MAA considers dysphagia ICD-9-CM diagnosis code 787.2 as medically necessary. The client must:

i. Require a thickener to aid in swallowing or currently be transitioning from tube feedings to oral feedings; and

ii. Have been evaluated by a speech therapist or an occupational therapist who specializes in dysphagia (the report recommending a thickener must be in the client chart in the prescriber's office).

MAA requires PA for "Simply Thick" (HCPCS B9998).

☞ **Note:** If the client is 20 years of age or younger and requires only a thickener, an evaluation by a dietician is not required.

4. Be 4 years of age or younger. **(Use EPA # 870001106 for a maximum of 1 year.)**

Client must have:

a) A certified registered dietician (RD) evaluation with recommendations (which support the prescriber's order) for medically necessary, oral enteral nutrition products or formulas; and

b) A signed and dated written notification from WIC indicating one of the following:

i. Client is not eligible for the WIC program; or
ii. Client is eligible for the WIC program, but the need for the oral enteral nutrition product or formula exceeds WIC's allowed amount; or
iii. The requested oral enteral nutrition product or formula is not available through the WIC program. (Specific, detailed documentation of the tried and failed efforts of similar WIC products, or the medical need for alternative products, must be in the prescriber's chart for the child); and

c) One of the following criteria:

i. Low birth weight (less than 2500 grams); or
ii. A decrease across two or more percentile lines on the CDC growth chart, once a stable growth pattern has been established; or
iii. Failure to gain weight on two successive measurements, despite dietary interventions; or
iv. Documented specific, clinical factors that place the child at risk for a compromised nutrition and/or health status.

5. Be 5 through 20 years of age. **(Use EPA # 870001107 for a maximum of 1 year.)**

Client must have:

a) A certified RD evaluation, for eligible clients, with recommendations (which support the prescriber's order) for medically necessary, oral enteral nutrition products; and

b) One of the following criteria:

i. A decrease across 2 or more percentile lines on the CDC growth chart, once a stable growth pattern has been established; or
ii. Failure to gain weight on two successive measurements, despite dietary interventions; or
iii. Documented specific, clinical factors that place the child at risk for a compromised nutrition and/or health status.

A client is eligible to receive delivery of orally administered enteral nutrition products in quantities sufficient to meet the client's medically authorized needs, not to exceed a 1-month supply. To receive the next month's delivery of authorized products, the client's file must show specific, detailed documentation of the necessity to refill the prescriber's order for the products. See Provider Requirements section for further details. **[Refer to WAC 388-554-300(5)]**

☞ **Note:** See the *Prior Authorization* section for details on PA and EPA.

# What further requirements must clients meet to be eligible for tube-delivered enteral nutrition products?

**[Refer to WAC 388-554-300(6)]**

To receive tube-delivered enteral nutrition products, necessary equipment, and supplies, a client must:

- Have a valid, written physician order from a physician, advanced registered nurse practitioner (ARNP), or physician's assistant-certified (PA-C) for all enteral nutrition products;
- Meet the conditions in these billing instructions;
- Be able to manage their tube feedings in one of the following ways:
  - ✓ Independently; or
  - ✓ With a caregiver who can manage the feedings; and
- Have at least one of the following medical conditions, subject to the criteria listed:
  - ✓ A nonfunction or disease of the structures that normally permit food to reach the small bowel; or
  - ✓ A disease or condition of the small bowel that impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength that is properly proportioned to the client's overall health status.

**Note:** Prior authorization is required for certain supplies and repairs. See the *Prior Authorization* section.

# Coverage

The Medical Assistance Administration (MAA) covers only the products listed in these billing instructions.

## What orally administered enteral nutrition products are covered? [Refer to WAC 388-554-500]

The enteral nutrition program covers medically necessary orally administered enteral nutrition products, subject to:

- Prior authorization requirements found in the Prior Authorization section of these billing instructions;
- Duration periods determined by MAA; and
- Delivery requirements found in the Provider Requirements section of these billing instructions.

## What tube-delivered enteral nutrition products, necessary equipment, and supplies are covered? [Refer to WAC 388-554-600]

The enteral nutrition program covers the following:

- Tube-delivered enteral nutrition products;
- Tube delivery supplies;
- Enteral nutrition pump rental (considered purchased after 12 months rental);
- Nondisposable intravenous (IV) poles required for enteral nutrition product delivery (one per client per lifetime);
- Purchased pump (one per client in a five year period); and
- Repairs to equipment.

# MAA Coverage for WIC Program-Eligible Clients

**[Refer to WAC 388-554-800]**

Clients who qualify for supplemental nutrition from the Women, Infants, and Children (WIC) program must receive supplemental nutrition through that program. MAA considers requests for enteral nutrition products and supplies for WIC program-eligible clients when all of the following are met:

- The vendor:
  - ✓ Receives a completed Expedited Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-761] from the prescriber;
  - ✓ Submits a Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-743] to MAA; or
  - ✓ Receives an order for tube-fed clients for the enteral nutrition product or supply from the prescriber.
- Specific, detailed documentation from the WIC program is attached to the request verifying that:
  - ✓ The client's enteral nutrition need is in excess of WIC program allocations. In these cases, MAA only reimburses for quantities in excess of WIC allocations; or
  - ✓ The WIC program cannot supply the prescribed product;
- The enteral nutrition products available through the WIC program cannot meet the client's nutritional needs; and
- The client meets the Enteral Nutrition program requirements in these billing instructions.

**For clients not eligible for the WIC program, providers must enter an "F" indicator in the Comments section of the claim form.**

☞ **Note:** For information regarding the WIC program, call 1-800-322-2588. A list of WIC-authorized formulas is on page E.6.

## What is not covered? [WAC 388-554-500(4)]

MAA does not cover or reimburse for orally administered enteral nutrition products when the client's nutritional need can be met using traditional foods, baby foods, and other regular grocery products that can be pulverized or blenderized and used to meet the client's caloric and nutritional needs.

> ☞ **Note:** MAA evaluates a request for orally administered enteral nutrition products and tube-delivered enteral nutrition products that are not covered or are in excess of the enteral nutrition program's limitations or restrictions, according to WAC 388-501-0165. **[WAC 388-554-500(6) and WAC 388-554-510(12)]**

## Medical Nutrition Therapy

MAA pays for medical nutrition therapy provided by a certified dietician who has a current MAA provider number (see note on page C.1), for clients 20 years of age and younger and on an eligible program, when the client is referred by an EPSDT provider.

> ☞ **Note:** All clients 20 years of age and younger and on an eligible program must be evaluated by a certified dietician with a current MAA provider number within 30 days of initiation of enteral nutrition products, and periodically (at the discretion of the certified dietician) while receiving enteral nutrition products. See Provider Requirements for further details. **[Refer to WAC 388-554-300(2)]**

Refer to MAA's current *Medical Nutrition Therapy Billing Instructions* for further information (see Important Contacts section for information on where to get copies of billing instructions).

## Clients in a State-Owned Facility [WAC 388-554-500(2a) and WAC 388-554-600(9a)]

MAA does not pay separately for orally administered enteral nutrition products or tube-delivered enteral nutrition products, necessary equipment, and supplies when a client resides in a state-owned facility (i.e., state school, developmental disabilities (DD) facility, mental health facility, Western State Hospital, and Eastern State Hospital).

## Clients in a Nursing Facility [WAC 388-554-500(3) and 388-554-600(10)]

MAA pays separately for an eligible client's orally administered enteral nutrition products when the client:

- Resides in the nursing facility;
- Meets the eligibility requirements found in the Client Eligibility section of these billing instructions; and
- Needs enteral nutrition products to meet 100% of the client's nutritional needs.

☞ **Note:** When billing for clients in nursing facilities who qualify for reimbursement of enteral nutrition, providers must add the statement *"100 % nutrition - not included in NH"* in the *Comments* section of the claim form.

## Clients Who Have Elected MAA's Hospice Benefit
**[WAC 388-554-500(2b) and 388-554-600(9b)]**

MAA does not pay separately for orally administered enteral nutrition products or tube-delivered enteral nutrition products, necessary equipment, and supplies when a client has elected and is eligible to receive MAA's hospice benefit, unless both of the following apply:

- The client has a pre-existing medical condition that requires enteral nutrition support; and
- The pre-existing medical condition is not related to the diagnosis that qualifies the client for hospice.

**Providers must enter a "K" indicator in the Comments section of the claim form to identify that the need for the enteral nutrition product, necessary equipment, or supply is unrelated to the terminal diagnosis.**

☞ **Note:** To ensure program compliance, MAA conducts post-pay reviews. Refer to WAC 388-502-0100, Payment -- Eligible providers defined.

## Clients Who Are Receiving Medicare Part B Benefits

MAA only pays for oral enteral nutrition for clients on Medicare Part B and when the client meets the criteria in these billing instructions.

When billing for these clients, providers must use the "BO" modifier. It is ***not*** necessary to submit a Medicare denial.

# Enteral Nutrition Products Used in Combination with Parenteral Nutrition

## Can I get paid for both enteral nutrition and parenteral nutrition?

MAA pays for enteral nutrition/supplies and parenteral nutrition/supplies only while a client is being transitioned from parenteral to enteral nutrition. Refer to MAA's current *Home Infusion Therapy/Parenteral Nutrition Billing Instructions.*

# WIC List

# Prior Authorization

## What is prior authorization?

Prior authorization (PA) is the Medical Assistance Administration's (MAA) approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization (EPA) and limitation extensions (LE) are forms of PA.**

## Is prior authorization required for enteral nutrition?

**[Refer to WAC 388-554-700]**

MAA requires PA for orally administered enteral nutrition products, repairs to equipment, and replacement of necessary supplies for tube delivery of enteral nutrition products. See also WAC 388-501-0165 - Determination process for coverage of medical equipment and medical or dental services.

When MAA receives an initial request for PA, the prescription(s) for those items cannot be older than 3 months from the initial request date.

MAA will evaluate all requests for services not specifically described in these billing instructions or that are in excess of the enteral nutrition program's limitations or restrictions, based on medical necessity. The vendor must furnish all of the following information to MAA:

- A copy of the completed Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-743] that includes the order completed by the prescribing physician, advanced registered nurse practitioner (ARNP), or physician's assistant-certified (PA-C), which includes client's medical condition and exact daily caloric amount of prescribed enteral nutrition product (see Important Contacts).

- Specific, detailed documentation from the client's physician, ARNP, or PA-C that verifies all of the following:

  - ✓ The client has at least one of the following medical conditions, subject to the criteria listed:

    - ➢ Malnutrition/malabsorption as a result of a stated primary diagnosed disease.

      Requires PA for a maximum of 1 year per request, and MAA considers the following ICD-9-CM codes as medically necessary: 260, 261, 263.0, 263.2, 579.0, 579.2, and 579.8. The client must have:

- ❖ A weight-for-length at or less than the fifth percentile if the client is younger than age 3;

- ❖ A Body Mass Index (BMI) of:

  - ❒ Less than or equal to the fifth percentile if the client is older than age 3 and younger than age 18; or

  - ❒ Less than or equal to 18.5 if the client is 18 years of age or older; or

- ➢ An unintentional or unexplained weight loss of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months.

- ➢ Acquired immune deficiency syndrome (AIDS).

  Requires PA for a maximum of 1 year per request, and MAA considers ICD-9-CM diagnosis code 042 as medically necessary. The client must:

  - ❖ Be in a wasting state; and

  - ❖ Have a weight-for-length at or less than the fifth percentile if the client is younger than age 3;

  - ❖ Have a BMI of:

    - ❒ Less than the fifth percentile if the client is older than age 3 and younger than age 18; or

    - ❒ Less than or equal to 18.5 if the client is 18 years of age or older; or

- ➢ An unintentional or unexplained weight loss of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months.

- ➢ Failure to thrive.

  Requires PA for a maximum of 1 year per request, and MAA considers ICD-9-CM diagnosis code 783.41 as medically necessary. The client must have:

  - ❖ A disease or medical condition that is only organic in nature and not due to cognitive, emotional, or psychological impairment; and
  - ❖ A weight-for-length at or less than the fifth percentile if the client is younger than age 3;
  - ❖ A BMI of:
    - ❒ Less than or equal to the fifth percentile if the client is at least age 3 but younger than age 18; or
    - ❒ Less than or equal to 18.5, **and** an albumin level of 3.5 or below, **and** a cholesterol level of 160 or below if the client is 18 years of age or older; or

- ➢ An unintentional or unexplained weight loss of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months.

- ✓ The client's physical limitations and expected outcome.
- ✓ The client's current clinical nutritional status, including the relationship between the client's diagnosis and nutritional need.
- ✓ For a client 18 years of age or older, the client's recent weight-loss history and a comparison of the client's actual weight to ideal body weight and current body mass index (BMI).
- ✓ For a client 17 years of age or younger, the client's growth history and a comparison to expected weight gain, and:
  - ➢ An evaluation of the weight-for-length percentile if the client is 2 years of age or younger; or
  - ➢ An evaluation of the BMI if the client is older than age 3 and younger than age 18.
- ✓ Specific, detailed documentation explaining why less costly, equally effective products or traditional foods are not appropriate (see Coverage section).

- ✓ The client's likely expected outcome if enteral nutritional support is not provided.
- ✓ Number of days or months the enteral nutrition products, equipment, and/or necessary supplies are required.

A provider may resubmit a request for prior authorization for oral enteral nutrition products or replacement of necessary supplies for tube delivery of enteral nutrition products that MAA has denied (see Important Contacts section); however, the provider must include new documentation that is relevant to the request.

# How do I request authorization for an emergency fill?

In emergency situations, providers may deliver enteral nutrition products that require PA without an authorization number for a maximum of a 3-day supply. However, in order to receive payment, the provider must fax justification for the request to MAA no later than the following working day after the fill.

# What is expedited prior authorization?

Expedited prior authorization (EPA) is a process designed to eliminate the need for fax requests for prior authorization for selected HCPCS codes. MAA allows payment during a limited time period for this process.

To bill MAA for enteral nutritional products and supplies that meet the EPA criteria on the following pages, the vendor must create a nine-digit EPA number using the following criteria:

## *EPA Numbers for Enteral Tubing, Pumps and Poles, and Enteral Nutrition Products*

The first 6 digits of the EPA number must be **870000.** The last 3 digits document the product description and conditions that make up the EPA criteria.

## *EPA Numbers for Medical Conditions*

The first 5 digits of the EPA number must be **87000.** The last 4 digits document the medical condition that makes up the EPA criteria.

## *EPA Requirements for Medical Conditions*

- For each EPA number, there must be a completed Expedited Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-761] in the client's file.

- Specific, detailed documentation explaining why trials of traditional foods did not meet the nutritional needs of the client must be in the prescriber's files. This information may be obtained from a family member or caregiver.

☞ **Note:** Each coverage period is for a maximum of 1 year, unless otherwise specified.

Enter the EPA number on the HCFA-1500 claim form in the **field 19** or in the ***Authorization*** or ***Comments*** field when billing electronically. With HIPAA implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. If you are billing **multiple** EPA numbers, you must list the 9-digit EPA numbers in *field 19* of the claim form ***exactly*** as follows (*not all required fields are represented in the example*):

| |
|---|
| 19. Line 1: 870000725/ Line 2: 870000726 |

If you are billing only one EPA number on a paper HCFA-1500 claim form, please continue to list the nine-digit EPA number in field 23 of the claim form.

**Example:** The 9-digit EPA number for Low Profile Gastrostomy Replacement Kit for a client that meets all of the EPA criteria would be **870000742** (870000 = first 6 digits, 742 = product and documented medical condition).

**Vendors are reminded that EPA numbers are only for those products listed in the fee schedule as requiring EPA numbers.** EPA numbers are not valid for:

- Other enteral nutrition products and supplies requiring prior authorization through the enteral nutrition program;
- Products for which the documented medical condition does not meet **all** of the specified criteria; or
- Limitation extensions.

Certain medical conditions require an EPA number which is valid for a limited amount of time only. If an extension is medically necessary, you must fax MAA a limitation extension request (see page F.10).

Providers must request PA from MAA when a situation does not meet the EPA criteria for a selected HCPCS code. Providers must fax a request to MAA's Enteral Nutrition Program Manager (see *Important Contacts* section).

***Expedited Prior Authorization Guidelines:***

**A.** **Medical Justification (criteria)** - Medical justification must come from the client's prescriber with an appropriately completed Expedited Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-761]. The vendor must use this form when using the EPA process. The client must meet the exact criteria in order for providers to use an EPA number. Specific, detailed documentation explaining why trials of traditional foods did not meet the nutritional needs of the client must be in the vendor's files. The EPA numbers have restricted time periods. If the client continues to meet the criteria when the restricted time period ends and the prescriber completes another Expedited Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-761], providers may continue to use the EPA number. If the client does not continue to meet the criteria, but needs an oral enteral nutrition product, providers must send in an appropriately completed Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-743].

**A.** **Documentation** - The billing vendor **must keep** the completed Expedited Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-761] in the client's file. Upon request, a vendor must provide specific, detailed documentation to MAA showing how the client's condition met the criteria for EPA. Vendors must keep documentation on file for 6 years. [Refer to WAC 388-502-0020]

☞ **Note:** To ensure program compliance, MAA conducts post-pay reviews. Refer to WAC 388-502-0100.

**Washington State**
**Expedited Prior Authorization Criteria Coding List**

| Code | Criteria | Code | Criteria |
|---|---|---|---|

**ENTERAL TUBING**
**Procedure Code: B9998**

**742 Low Profile Gastrostomy Replacement Kit**

Covered with EPA for a maximum of 2 per client, every 5 months.

**Procedure Code: E1399**

**743 Repair Parts for Enteral Equipment**

Covered with EPA for those client-owned pumps less than 5 years old, and no longer on warranty. Invoice required.

**PUMPS AND POLES**
**Procedure Code: B9998**

**744 Case for Ambulatory Feeding Pump.**

Covered with EPA for a maximum of 1 case per 5 years.

**ENTERAL NUTRITION PRODUCTS**
**Procedure Code: B9998**
***Use EPA for a maximum of one year.***

**868 Nutritional Bars**

Authorized only for clients:

- With chronic renal failure on dialysis; and
- On fluid restrictive diets.

**Note:** When EPA limits are exceeded, see "How do I request a limitation extension?" on page F.10.

**MEDICAL CONDITIONS**
***EPA coverage period is for a maximum of one year unless otherwise specified.***

**1100 Chronic Renal Failure**
**ICD-9-CM Diagnosis Code 585.6**

The client must be receiving dialysis.

☞ **Note:** Clients receiving dialysis must have a fluid restrictive diet to use nutrition bars. When billing for nutrition bars, use EPA # 870000868.

**1101 Cancer(s)**
**ICD-9-CM Diagnosis Codes: 140 through 208.9 and 230 through 234.9**

The client must be currently receiving chemotherapy and/or radiation therapy. Providers may also use this code to bill for the post therapy phase (up to 3 months following the completion of chemotherapy or radiation therapy).

**1102 Decubitus Pressure Ulcer(s)**
**ICD-9-CM Diagnosis Code 707.0 – 707.09**
***Use EPA for a maximum of three months.***

The client must have:

- Stage 3 or greater decubitus pressure ulcer(s); and
- An albumin level of 3.2 or below.

**1103 Amino Acid, Fatty Acid, and Carbohydrate Metabolic Disorders ICD-9-CM Diagnosis Codes: 270-270.8, 271-271.8, and 272.0-272.8**

The client must require a specialized oral nutritional product.

**1104 Medical Condition Requiring Thickeners (Procedure Code: B4100) for Dysphagia ICD-9-CM Diagnosis Code: 787.2**

The client must:

- Require a thickener to aid in swallowing or be currently transitioning from tube feedings to oral feedings; and
- Have been evaluated by a speech therapist, or an occupational therapist that specializes in dysphagia (the report must be in the client's chart in the prescriber's office recommending a thickener).

☞ **Note:** If the client is 20 years of age or younger and only requires a thickener, an evaluation by a dietician is not required.

"Simply Thick" (B9998) continues to require prior authorization for pricing.

**1105 End Stage COPD or Emphysema ICD-9-CM Diagnosis Codes 491.20, 491.21, 492.8, 496**

Client must have:

- A BMI 18.5 or less; or
- An unintentional or unexplained weight loss of 5% in 1 month, or 7.5% in 3 months, or 10% in 6 months.

**AGE REQUIREMENTS**

**1106 Children four years of age or younger (younger than five years of age)**

Client must have:

✓ A certified RD evaluation with recommendations (which support the prescriber's order) for medically necessary, oral enteral nutrition products or formulas; and

✓ A signed and dated written notification from WIC indicating one of the following:

- ➢ Client is not eligible for the WIC program; or
- ➢ Client is eligible for the WIC program, but the need for the oral enteral nutrition product or formula exceeds WIC's allowed amount; or
- ➢ The requested oral enteral nutrition product or formula is not available through the WIC program. (Specific, detailed documentation of the tried and failed efforts of similar WIC products, or the medical need for alternative products, must be in the prescriber's chart for the child); and

- ✓ One of the following criteria:
  - ➢ Low birth weight (less than 2500 grams); or
  - ➢ A decrease across 2 or more percentile lines on the CDC growth chart, once a stable growth pattern has been established; or
  - ➢ Failure to gain weight on 2 successive measurements, despite dietary interventions; or
  - ➢ Documented specific, clinical factors that place the child at risk for a compromised nutrition and/or health status.

**1107 Children 5 through 20 years of age (younger than 21 years of age)**

Client must have:

- ✓ A certified RD evaluation, for eligible clients, with recommendations (which support the prescriber's order) for medically necessary, oral enteral nutrition products; and
- ✓ One of the following criteria:
  - ➢ A decrease across 2 or more percentile lines on the CDC growth chart, once a stable growth pattern has been established; or
  - ➢ Failure to gain weight on 2 successive measurements, despite dietary interventions; or
  - ➢ Documented specific, clinical factors that place the child at risk for a compromised nutrition and/or health status.

# What is a limitation extension?

A limitation extension is when MAA allows additional units of service for a client when the provider can verify that the additional units of supplies are medically necessary. Limitation extensions require prior authorization.

> ☞ **Note:** Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

# How do I request a limitation extension?

When the physician determines that additional supplies are medically necessary for the client, the vendor must request MAA-approval in writing.

**The written requests must include the following:**

1. The name and PIC number of the client;
2. The provider's name, provider number, telephone number, and fax number;
3. Additional supply(s) requested;
4. Copy of new prescription and date dispensed;
5. Copy of the Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-743] or the Justification for use of B9998 Miscellaneous Enteral Nutrition Procedure Code and Limitation Extension Request Form [DSHS 13-745] (see Important Contacts);
6. The primary ICD-9-CM diagnosis code and HCPCS code; and
7. Client-specific clinical justification for additional supplies.

*For additional units of supplies*, fax the above information to the MAA Enteral Nutrition Program Manager (see the Important Contacts section).

# Modifiers

Providers must use the procedure codes listed in the product list along with the appropriate modifier for all enteral nutrition products. HRSA denies claims for enteral nutrition products without modifiers.

## Modifier 'BA'

Use Modifier 'BA' for medically necessary, ***tube-delivered enteral nutrition products and supplies***, not orally administered nutrition.

## Modifier 'BO'

Use Modifier 'BO' for medically necessary, ***orally administered enteral nutrition products***, not nutrition administered by external tube.

All enteral nutrition products must have documented justification for medical necessity in the client's file and made available for review by HRSA. Claims for reimbursement of nutrition products must be billed with the ICD-9-CM diagnosis code(s).

> **Note:** Medicare Part B covers enteral nutrition products only for clients who are tube-fed. Enteral nutrition products being appropriately billed with a 'BO' modifier will not require a Medicare denial and can be billed directly to HRSA.

Providers must use the procedure codes listed in the fee schedule along with the appropriate NU or RR modifier for all poles and pumps.

## Modifier 'NU'

Use Modifier 'NU' to indicate that the provider is billing HRSA for new, purchased equipment.

## Modifier 'RR'

Use Modifier 'RR' to indicate that the provider is billing HRSA for rental equipment.

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# Product List

## Enteral Nutrition Product Classification List

Vendors must use the Enteral Nutrition Product Classification List located on the SADMERC* web site http://www.palmettogba.com to locate proper HCPCS coding for products requested. Providers must use the applicable HCPCS codes for all enteral nutritional claims. MAA will **only** accept billing for codes and products listed on the SADMERC Enteral Nutrition Product Classification List.

☞ **Note: The appropriate modifier must be used (see page G.1) when billing MAA for these codes.**

Billing must be limited to a 1-month supply.

MAA does not reimburse for puddings and shakes.

The following table is a list of acceptable CMS HCPCS codes and MAA's maximum allowable fees:

| Category (HCPCS code) | Description | One Unit Equals | Maximum Allowable Fee |
|---|---|---|---|
| **B4100** | Food thickener administered orally per ounce. ***Thickeners when EPA criteria for EPA # 870001104 is met. Includes Resource ThickenUp, Thick & Easy, and Thick-It.*** | One powdered oz | $0.56 |
| **B4149** | Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber. . | 100 cal | $1.53 |
| **B4150** | Enteral formula consisting of semi-synthetic intact protein/protein isolates. | 100 cal | $0.79 |
| **B4152** | Intact protein/protein isolates (calorically dense). | 100 cal | $0.59 |
| **B4153** | Hydrolized protein/amino acids. | 100 cal | $2.41 |
| **B4154** | Defined formula for special metabolic need. | 100 cal | $1.39 |
| **B4155** | Modular components. | 100 cal | $0.93 |

* The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) is a national entity that provides services under contract to the Centers for Medicare & Medicaid Services (CMS). The SADMERC Reports and Analysis Unit provides data analysis support to the four DMERCs. The SADMERC HCPCS Unit offers guidance to manufacturers and suppliers on the proper use of the Healthcare Common Procedure Coding System (HCPCS)

| Category (HCPCS code) | Description | One Unit Equals | Maximum Allowable Fee |
|---|---|---|---|
| **B4157** | Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber. | 100 cal | $1.39 |
| **B4158** | Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron. | 100 cal | $0.79 |
| **B4159** | Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron. | 100 cal | $0.79 |
| **B4160** | Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber. | 100 cal | $0.59 |
| **B4161** | Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber. | 100 cal | $2.41 |
| **B4162** | Enteral formula, for pediatrics, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber. | 100 cal | $1.39 |
| **B9998** | NOC for enteral supplies. ***Nutrition bars when EPA criteria for EPA # 870000868 is met. Includes Choice DM Bar, Ensure Bar, Glucerna Bar, Protein Eight Bar, Regain Bar, and Resource Bar.*** | One Bar | $0.72 |
| **B9998** | Simply-Thick Honey thickener | One box of 100 count | PA for pricing Invoice required |
| **B9998** | Simply-Thick Nectar thickener | One box of 200 count | PA for pricing Invoice required |

# Product Classification

Based on the Centers for Medicare/Medicaid Services (CMS) guidelines, enteral nutrition formulas are placed in categories based on the composition and source of the ingredients in each product. Each category has a corresponding HCPCS code. These categories are listed below:

| Category (HCPCS code) | Description |
|---|---|
| **B4149** | Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber. |
| **B4150** | Enteral formula consisting of semi-synthetic intact protein/protein isolates. |
| **B4152** | Intact protein/protein isolates (calorically dense). |
| **B4153** | Hydrolized protein/amino acids. |
| **B4154** | Defined formula for special metabolic need. |
| **B4155** | Modular components. |
| **B4157** | Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber. |
| **B4158** | Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron. |
| **B4159** | Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron. |
| **B4160** | Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber. |
| **B4161** | Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber. |
| **B4162** | Enteral formula, for pediatrics, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber. |

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# Reimbursement

## What is included in MAA's reimbursement? [Refer to WAC 388-540- 600 (5)-(8)]

MAA's reimbursement for covered enteral nutrition equipment and necessary supplies includes all of the following:

- Any adjustments or modifications to the equipment required within three months of the date of delivery. This does not apply to adjustments required because of changes in the client's medical condition;
- Fitting and set-up; and
- Instruction to the client or the client's caregiver in the appropriate use of the equipment and necessary supplies.

A provider is responsible for any costs incurred to have another provider repair equipment if all of the following apply:

- Any equipment that MAA considers purchased requires repair during the applicable warranty period;
- The provider refuses to or is unable to fulfill the warranty; and
- The client still needs the equipment.

MAA rescinds any authorization for prescribed equipment if the equipment was not delivered to the client before the client:

- Loses medical eligibility;
- Becomes covered by a hospice agency and the equipment is used in the treatment of the terminal diagnosis or related condition(s);
- Becomes eligible for an MAA managed care plan; or
- Dies.

MAA covers enteral nutrition equipment rental for up to 12 months. After 12 months of rental, MAA considers the equipment to be purchased and it becomes the client's property.

MAA requires a provider to furnish clients new or used equipment that includes full manufacturer and dealer warranties for one year.
If the rental equipment must be replaced during the warranty period, MAA recoups 50% of the total amount previously paid toward rental and eventual purchase of the equipment delivered to the client. All of the following must apply:

- The provider is unwilling or unable to fulfill the warranty; and
- The client still needs the equipment.

# Fee Schedule

## Equipment Rental/Purchase Policy

- The following are included in MAA's reimbursement for equipment rentals or purchases:

  ✓ Instructions to the client and/or caregiver on the safe and proper use of equipment provided;
  ✓ Full service warranty;
  ✓ Delivery and pick-up; and
  ✓ Fitting and adjustments.

- If changes in circumstances occur during the rental period, such as death or ineligibility, MAA will terminate reimbursement at that date.

- Providers may not bill for a rental and a purchase of any item simultaneously.

- MAA will ***not*** reimburse providers for equipment that was supplied to them **at no cost** through suppliers/manufacturers.

- All rent-to-purchase equipment may be new or used at the beginning of the rental period.

- MAA reimburses for enteral nutrition related supplies for clients residing in nursing facilities **only when:**

  ✓ The supplies are used to administer 100% of the client's nutritional requirements; and
  ✓ The client's medical circumstances meet MAA's program requirements for enteral nutrition.

  ☞ **Note:** Covered items that are not part of the nursing facility per diem may be billed separately to MAA.

- MAA reimburses for enteral nutrition-related supplies for clients receiving Medicare Part B **only when:**

  ✓ The supplies are used to administer enteral nutrition products to non tube-fed clients; and
  ✓ The client's medical circumstances meet MAA's requirements for enteral nutrition.

## Enteral Supply Kits

- **Do not bill more than one supply kit code per day.**
- **Enteral supply kits include all the necessary supplies for the enteral patient using the syringe, gravity or pump method of nutrient administration.**
- **Bill only for the actual number of kits used, not to exceed a one-month supply.**

| Procedure Code | Description | Maximum Allowable Fee | Rental | Purchase | Maximum Number of Units | Part of NH per diem |
|---|---|---|---|---|---|---|
| B4034-BA | Enteral Feeding Supply Kit; Syringe (Bolus only) | $5.66 | N | Y | 1 per client, per day | N |
| B4035-BA | Enteral Feeding Supply Kit; Pump Fed, per day | $10.78 | N | Y | 1 per client, per day | N |
| B4036-BA | Enteral Feeding Supply Kit; Gravity Fed | $7.38 | N | Y | 1 per client, per day | N |

## Enteral Tubing

- **The total number of allowed tubes includes any tubes provided as part of the replacement kit.**

| Procedure Code | Description | Maximum Allowable Fee | Rental | Purchase | Maximum Number of Units | Part of NH per diem |
|---|---|---|---|---|---|---|
| B4081-BA | Nasogastric tubing with stylet (each) | $19.98 | N | Y | 3 per client, per month | N |
| B4082-BA | Nasogastric tubing without stylet (each) | $14.88 | N | Y | 3 per client, per month | N |
| B4083-BA | Stomach tube – Levine type (each) | $2.27 | N | Y | 1 per client, per month | N |
| B9998 | Low Profile Gastrostomy Replacement Kit (e.g., Bard, MIC Key Button, Hide-a-port, Stomate) **EPA #: 870000742** | $106.87 | N | Y | 2 per client, every 5 months | N |
| B4086-BA | Gastrostomy/jejunostomy tube, any material, any type (standard or low profile), each | $32.89 | N | Y | 5 per client, per month | N |

## Enteral Repairs

| Procedure Codes | Description | Maximum Allowable Fee | Rental | Purchase | Maximum Number of Units | Part of NH per diem |
|---|---|---|---|---|---|---|
| E1399 | Repair Parts for Enteral Equipment. ***Only*** those client-owned pumps less than five (5) years old, and no longer under warranty will be allowed replacement parts. **EPA #: 870000743 (Invoice required.)** | 85% | N/A | N/A | | N |
| E1340 | Repair or nonroutine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes. | $17.43 | N/A | N/A | | N |
| | | | | | | |

## Pumps and Poles

- **Poles are considered purchased after 12 months' rental.**
- **Pumps may be new or used equipment at beginning of rental period (See page D.2).**

| Procedure Code | Description | Maximum Allowable Fee | Rental | Purchase | Maximum Number of Units | Part of NH per diem |
|---|---|---|---|---|---|---|
| E0776-NU | IV pole. Purchase. Nondisposable. Modifier required. | $99.49 | N | Y | 1 per client, per lifetime | Y |
| E0776-RR | IV pole. Rental. Nondisposable. Modifier required. | $9.94 | Per month | N | 1 per month; not to exceed 12 months | Y |
| B9998 | Case for ambulatory feeding pump. Included in pump purchase. **EPA #: 870000744.**- | $101.59 | N | Y | 1 every 5 years | N |
| B9002-RR | Enteral nutrition infusion pump with alarm. | $109.75 | Per month | N | 1 per month; not to exceed 12 months | N |

| Miscellaneous | | | | | | |
|---|---|---|---|---|---|---|
| • **MAA review is required prior to billing this code.** | | | | | | |
| **Procedure Code** | **Description** | **Maximum Allowable Fee** | **Rental** | **Purchase** | **Maximum Number of Units** | **NH per diem** |
| B9998 | NOC for enteral supplies (other enteral nutrition supplies not listed). | To be determined by MAA. **Prior authorization is required.** | | | | N |

# Miscellaneous Procedure Code

In order to be reimbursed for miscellaneous enteral nutrition procedure code B9998, all the information in the "Justification for use of B9998 Miscellaneous Enteral Nutrition Procedure Code and Limitation Extension Request Form" [DSHS Form # 13-745] must be submitted to the MAA Enteral Nutrition Program Manager prior to submitting your claim to MAA (see *Important Contacts* for information on how to access this form).

**Do not submit claims using procedure code B9998 until you have received an authorization number from MAA indicating that your bill has been reviewed and the payable amount determined.**

Include the following supporting documentation with your fax:

- Agency name and provider number;
- Client PIC;
- Date of service;
- Name of piece of equipment;
- Invoice;
- Prescription;
- Explanation of client-specific, medical necessity; and
- Name of primary piece of equipment and whether the equipment is rented or owned.

# Billing

## What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA has two timeliness standards for: 1) initial claims; and 2) resubmitted claims.

- ***Initial Claims***

  - ✓ MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

    - ➢ The date the provider furnishes the service to the eligible client;
    - ➢ The date a final fair hearing decision is entered that impacts the particular claim;
    - ➢ The date a court orders MAA to cover the services; or
    - ➢ The date DSHS certifies a client eligible under delayed[1] certification criteria.

  - ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

    - ➢ DSHS certification of a client for a retroactive[2] period; or
    - ➢ The provider proves to MAA's satisfaction that there are extenuating circumstances.

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[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

**Eligibility Established After Date of Service but Within the Same Month -** If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- ***Resubmitted Claims***

  Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the time period listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

# What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

# How do I bill for services provided to Primary Care Case Management (PCCM) clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM provider name in field 17 of the HCFA-1500 claim form; and
- Enter the seven-digit, MAA-assigned identification number of the PCCM provider who referred the client for the service(s). If the client is enrolled with a PCCM provider and the PCCM referral number is not in field 17 when you bill MAA, the claim will be denied.

# How do I bill for clients who are eligible for both Medicare and Medicaid?

If a client is eligible for both Medicare and Medicaid, **you must *first* submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within 12 months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims.

## QMB (Qualified Medicare Beneficiaries) Program Limitations:

**QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)**

(Clients who have CNP or MNP identifiers on their medical ID card in addition to QMB)

- If Medicare ***and*** Medicaid cover the services, MAA will pay only the deductible and/or coinsurance up to Medicare's or Medicaid's allowed amount, whichever is less.
- If only Medicare ***and not Medicaid*** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.
- If only Medicaid ***and not Medicare*** covers the service and the service is covered under the CN or MN program, MAA will reimburse for the service.

## QMB-Medicare Only

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare's or Medicaid's allowed amount, whichever is less.
- If only Medicare ***and not Medicaid*** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.
- If **Medicare does not** cover the service, MAA will not reimburse the service.

# Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's DSHS Medical ID Card. An insurance carrier's time limit for claim submissions may be different. It is your responsibility to meet MAA's and the insurance carrier's requirements relating to billing time limits, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov/download/hcarrier.txt, or by calling the Coordination of Benefits Section at 1-800-562-6136.

# What records must be kept? [Refer to WAC 388-502-0020]

**Enrolled providers must:**

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications (including NDC numbers), equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, ***for at least 6 years from the date of service*** or more if required by federal or state law or regulation.

**A provider may contact MAA with questions regarding MAA's programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.**
**[Refer to WAC 388-502-0020(2)]**

# What records specific to MAA's Enteral Nutrition program must be kept? [Refer to WAC 388-554-400(2)(g)]

Providers must keep legible, accurate, and complete charts in the clients' records to justify the medical necessity of the items provided.

## For oral enteral nutrition products

***Medical vendors or pharmacies must keep the following in their files:***

- A copy of one of the following completed forms:
  - ✓ The Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-743] with the authorization number provided by MAA. The prescription is a part of the form; or
  - ✓ Expedited Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-761]. This form must be filled out in its entirety. The client must meet the exact criteria in order for the vendor to use an EPA number. In order to continue to use this form when the allowed time period ends, the prescriber must complete a new form, and the vendor must verify the EPA criteria are still met. The client must continue to meet the exact criteria in order for the vendor to use an EPA number. If the criteria are not met, a completed Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-743] must be submitted.
- A copy of the WIC denial for clients younger than age 5. The denial must state:
  - ✓ The client is not eligible for WIC program services;
  - ✓ The client is eligible for WIC program services, but nutrition needs exceed the WIC program's maximum per calendar month allotment; or
  - ✓ The WIC program cannot provide the prescribed product.
- A copy of the dietician evaluation for clients 20 years of age and younger who are on an eligible program.

***Prescribers must keep the following in their files:***

- A copy of one of the following completed forms:
  - ✓ The Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-743]; or
  - ✓ The Expedited Prior Authorization Request/Oral Enteral Nutrition Worksheet [DSHS 13-761].
- Specific, detailed documentation of reasons why trials of traditional foods did not meet the nutritional needs of the client.
- A copy of the dietician evaluation for clients 20 years of age and younger who are on an eligible program.
- Specific, detailed documentation that the WIC products have been tried and failed or that they are contraindicated when the client is eligible for the WIC program but the product you are ordering is not on the WIC product list.

## For tube-fed enteral nutrition products and supplies

***Medical vendors or pharmacies must keep the following in their files:***

- A copy of the prescription which is signed and dated by the prescriber and lists the client's medical condition and the exact daily caloric amount of medically necessary enteral nutrition product.
- A copy of the WIC denial for clients younger than age 5.
- A copy of the dietician evaluation for clients 20 years of age and younger who are on an eligible program.

***Prescribers must keep the following in their files:***

A copy of the dietician evaluation for clients 20 year of age and younger who are on an eligible program.

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# How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

## *Guidelines/Instructions:*

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner ***cannot read*** black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

- **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i. (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or not too light!**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

**FIELD DESCRIPTION**

**1a.** ***Insured's I.D. No.***: Required. Enter the MAA Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each MAA client - exactly as shown on the client's Medical ID card. This information consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder *before* adding the tiebreaker.
d) An alpha or numeric character (tiebreaker).

*For example:*

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

***NOTE:*** Use the PIC code of either parent if a newborn has not been issued a PIC. Enter a **B** in *field 19* to indicate the baby is on a parent's PIC.

**2.** ***Patient's Name***: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

**3.** ***Patient's Birthdate***: Required. Enter the birthdate of the MAA client.

**4**. ***Insured's Name (Last Name, First Name, Middle Initial)***: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

**5.** ***Patient's Address***: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

**9.** ***Other Insured's Name***: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

**9a**. Enter the other insured's policy or group number *and* his/her Social Security Number.

**9b**. Enter the other insured's date of birth.

**9c**. Enter the other insured's employer's name or school name.

**9d**. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

**Please note:** DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are *inappropriate* entries for this field.

**10**. ***Is Patient's Condition Related to***: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24. Indicate the name of the coverage source in field 10d* (L&I, name of insurance company, etc.).

**11**. ***Insured's Policy Group or FECA (Federal Employees Compensation Act) Number***: Primary insurance. When applicable. This information applies to the insured person listed in *field 4.* Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

**11a.** ***Insured's Date of Birth***: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3.*

**11b.** ***Employer's Name or School Name***: Primary insurance. When applicable, enter the insured's employer's name or school name.

**11c.** ***Insurance Plan Name or Program Name***: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

**11d.** ***Is There Another Health Benefit Plan?*:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim could be processed and denied in error.

**17.** ***Name of Referring Physician or Other Source***: When applicable, enter the referring physician or Primary Care Case Manager name. This field *must* be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

**17a.** ***I.D. Number of Referring Physician***: Required.

**19.** ***Reserved For Local Use***: When applicable, enter indicator **B** to indicate *Baby on Parent's PIC.* (Please specify twin A or B, triplet A, B, or C here.) **If you have more than one EPA number to bill, place both numbers here.**

**21.** ***Diagnosis or Nature of Illness or Injury***: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

**22.** ***Medicaid Resubmission***: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

**24.** ***Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form***.

**24A.** ***Date(s) of Service***: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., May 4, 2005 = 050405).

**24B.** ***Place of Service***: Required. These are the only appropriate code(s) for Washington State Medicaid:

| **Code Number** | **To Be Used For** |
|---|---|
| 12 | Client's residence |
| 13 | Assisted living facility |
| 14 | Group home |
| 31 | Skilled nursing facility |
| 32 | Nursing facility |

**24C.** ***Type of Service***: Not Required.

**24D.** ***Procedures, Services or Supplies CPT/HCPCS***: Required. Enter the appropriate HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed. ***MODIFIER***: When appropriate enter a modifier.

**24E.** ***Diagnosis Code***: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM.

**24F.** ***$ Charges***: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

**24G.** ***Days or Units***: **Required.** For multiple quantities of supplies, enter the number of items dispensed and all of the dates or dates spanned that the supplies were used. Unless the procedure code description specifically indicates pack, cans, bottles, or other quantity, the "each" is each single item.

**25.** ***Federal Tax I.D. Number*****: Leave this field blank.**

**26.** ***Your Patient's Account No.***: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

**28.** ***Total Charge***: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

**29.** ***Amount Paid***: Required if you receive an insurance payment or client-paid amount, show the amount of the insurance payment here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not put Medicare payment here or use dollar signs or decimals in this field.

**30.** ***Balance Due***: Required only when there is an amount entered in field 24. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

**33.** ***Physician's, Supplier's Billing Name, Address, Zip Code and Phone #***: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

***P.I.N.***: **Required.** Please enter your seven-digit provider number assigned by MAA.

# Sample HCFA-1500 Claim Form With PA

# Sample HCFA-1500 Claim Form With EPA

# How to Complete the Medicare Part B/Medicaid Crossover HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

**The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, *cannot* be billed electronically.**

## General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

**FIELD DESCRIPTION**

**1a**. ***Insured's I.D. No.***: Required. Enter the MAA Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical ID card. This information consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder *before* adding the tiebreaker.
d) An alpha or numeric character (tiebreaker).

*For example:*

1. Mary C. Johnson's PIC looks like this: C010633JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

**2.** ***Patient's Name***: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

**3.** ***Patient's Birthdate***: Required. Enter the birthdate of the MAA client. ***Sex***: Check **M** (male) or **F** (female).

**4**. ***Insured's Name (Last Name, First Name, Middle Initial)***: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

**5.** ***Patient's Address***: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*).

**9.** ***Other Insured's Name***: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

**9a**. Enter the other insured's policy or group number *and* his/her Social Security Number.

**9b**. Enter the other insured's date of birth.

**9c**. Enter the other insured's employer's name or school name.

**9d**. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

**Please note:** DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are *inappropriate* entries for this field.

**10**. ***Is Patient's Condition Related To***: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

**11**. ***Insured's Policy Group or FECA (Federal Employees Compensation Act) Number***: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

**11a.** ***Insured's Date of Birth***: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

**11b.** ***Employer's Name or School Name***: Primary insurance. When applicable, enter the insured's employer's name or school name.

**11c.** ***Insurance Plan Name or Program Name***: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

**11d.** ***Is There Another Health Benefit Plan?*:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim could be processed and denied in error.**

**19.** ***Reserved For Local Use* - Required.** When Medicare allows services, enter *XO* to indicate this is a crossover claim.

**22.** ***Medicaid Resubmission***: When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

**24.** ***Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form***.

**24A.** ***Date(s) of Service***: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., May 4, 2005 = 050405).

**24B.** ***Place of Service***: Required. Enter the appropriate number below:

| **Code Number** | **To Be Used For** |
|---|---|
| 12 | Client's residence |
| 13 | Assisted living facility |
| 14 | Group home |
| 31 | Skilled Nursing facility |
| 32 | Nursing facility |

**24C.** ***Type of Service***: Not required.

**24D.** ***Procedures, Services or Supplies CPT/HCPCS***: Required. ***Coinsurance and Deductible***: Enter the total combined and deductible for each service in the pace to the right of the modifier on each detail line.

**24E.** ***Diagnosis Code***: Enter appropriate diagnosis code for condition.

**24F.** ***$ Charges***: Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

**24G.** ***Days or Units***: For multiple quantities of supplies, enter the number of items dispensed and all of the dates or dates spanned that the supplies were used. Unless the procedure code description specifically indicates pack, cans, bottles, or other quantity, the "each" is each single item.

**24K.** ***Reserved for Local Use***: Required. Use this field to show Medicare's allowed charges. Enter the Medicare's allowed charge on each detail line of the claim (see sample).

**26.** ***Your Patient's Account No.***: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

**27.** ***Accept Assignment***: ***Required***. Check **yes.**

**28.** ***Total Charge***: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

**29.** ***Amount Paid***: Required. Enter the *Medicare Deductible* here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

**30.** ***Balance Due***: Required. Enter the *Medicare Total Payment*. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

**32.** ***Name and Address of Facility Where Services Are Rendered***: Required only when there is a Medicare deductible. Enter Medicare Statement Date ***and*** any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

**33.** ***Physician's, Supplier's Billing Name, Address, Zip Code and Phone #***: Required. Enter the supplier's *Name, Address,* and *Phone #* on all claim forms. Enter your seven-digit provider number here.

***P.I.N.***: **Required.** Please enter your seven-digit provider number assigned by MAA.

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